INSTRUCTIONS

PART A – To be completed by Service Member

Section 1 – Service Member Information

Section 1 of the form requests identifying information for the service member on whose behalf the benefit will be paid.

Section 2 – Guardian or Attorney in Fact Information

If anyone other than the service member will receive payment, please include copies of the letters of guardianship, conservatorship, or Power of Attorney, etc. with this form. Failure to include this documentation will delay payment of the benefit. If there is a Guardian or Attorney in Fact, Alliance Account payment is not an option.

Section 3 – Payment Information

Section 3 requests selection of a payment method for the TSGLI benefit. Only one method of payment should be selected. If payment is being made to the service member, only EFT or Alliance Account may be selected. If payment is being made to a guardian or Attorney in Fact, only EFT or check may be selected.

If the payment is to be deposited electronically into the service member's account, please check the Electronic Funds Transfer (EFT) box and complete the banking information. All information is required.

If the payment is to be deposited into an Alliance Account and a checkbook mailed to the service member, please check the Prudential's Alliance Account® box and complete the address to which the checkbook should be sent. Alliance Account checkbooks are sent by overnight delivery and, therefore require a street address. They cannot be delivered to Post Office boxes.

If neither method is indicated on the form, and there is no guardian or Attorney in Fact, the benefit will be paid through the Alliance Account. The checkbook will be mailed to the address of record listed in Section 1.

Section 4 – Signature

The service member, guardian, or Attorney in Fact must sign this section.

Section 5 – Authorization to Release Information

The Authorization to Release Information must be completed and signed by the service member, guardian, or Attorney in Fact.

PART B – Physician's Statement

The Physician's Statement asks the attending physician (military or civilian) to give details of the injuries that qualify the service member for the TSGLI benefit. The service member should complete Item 1, Service Member's Name and fill in the his or her Social Security Number at the top of both pages.

The attending physician must complete all sections that are applicable to the service member's injuries. Where a narrative description is required, please be complete and concise. For all sections, except the signature, please type or print legibly.

PART C – To be completed by the Branch of Service (after receipt of completed parts A and B by the Branch of Service)

Section 6 – Traumatic Event Information

Section 6 of the form requests information about the traumatic event that caused the service member's injuries.

If the service member is deceased, please submit a copy of the Report of Casualty (DD-1300) and Form SGLV-8286, indicating the SGLI beneficiaries.

Section 7 – Certification by Branch of Service

Section 7 of the form requests the Branch of Service to certify the service member's SGLI coverage and to verify that the event that caused the service member's injuries qualifies under the regulations that govern this coverage. If the service member had declined SGLI coverage, please submit a copy of the Form SGLV-8286 indicating the declination.

Certification of Traumatic Injury Protection (TSGLI)
Part A—To Be Completed by Service Member

1 Service member Information

First Name | MI | Last Name

Social Security Number | Date of Birth (MM DD YYYY) | Gender ☐ Male ☐ Female

Branch of Service | ☐ Active Duty ☐ Reserves ☐ National Guard | Telephone

Address of Record (number and street) | Apartment (if any)

City | State | ZIP Code

E-mail Address

2 Guardian or Attorney in Fact Information

Important Note: Please include copies of the letters of guardianship, conservatorship, or Power of Attorney, etc. with this form. Failure to include this documentation will delay payment of the claim.

If a guardian or an Attorney in Fact will receive payment, please complete the following:

First Name | MI | Last Name

Mailing Address (number and street) | Apartment (if any)

City | State | ZIP Code

Telephone Number | Fax Number

3 Payment Information (Please select only one method of payment)

☐ **Electronic Funds Transfer (EFT)** (Available to service member, guardian, or Attorney in Fact)

Bank Name | Bank Phone Number

Bank Routing Number | Bank Account Number | ☐ Savings ☐ Checking

Account Owner's Name

First Name | MI | Last Name

Note: Please enter street address only. No P.O. Boxes

☐ **Prudential's Alliance Account®*** (Available to service member only)

Mailing Address for Payment | Apartment, Ward or Room (if any)

City | State | ZIP Code

☐ **Payment by Check** (Available to guardian, or Attorney in Fact)

4 Signature

X

Signature of service member, guardian, or Attorney in Fact | Date (MM DD YYYY) | Description of Authority

Service member's Social Security Number

Certification of Traumatic Injury Protection (TSGLI)

5 Authorization for Release of Information to Branch of Service and Office of Servicemembers' Group Life Insurance

This authorization is intended to comply with the HIPAA Privacy Rule

Name of Insured:

First Name | MI | Last Name

Date of Birth (MM DD YYYY) | Social Security Number

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, medical examiner or other health care provider that has provided treatment, payment or services pertaining to:

First Name | MI | Last Name

Print Name of Service member

or on my (his/her) behalf ("My Providers") to disclose my (his/her) entire medical record for me or my dependents and any other health information concerning me (him/her) to the Branch of Service and Office of Service members' Group Life Insurance (OSGLI) and its agents, employees, and representatives. Office of Servicemembers' Group Life Insurance (OSGLI) is a division of The Prudential Insurance Company of America, headquartered in Newark, New Jersey. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I authorize all non-health organizations, any insurance company, employer, or other person or institutions to provide any information, data or records relating to credit, financial, earnings, travel, activities or employment history to OSGLI.

Unless limits* are shown below, this form pertains to all of the records listed above.

By my signature below, I acknowledge that any agreements I (he/she) have made to restrict my (his/her) protected health information do not apply to this authorization and I instruct My Providers to release and disclose my (his/her) entire medical record without restriction.

This information is to be disclosed under this Authorization so that my Branch of Service and OSGLI may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits, 2) obtain reinsurance; 3) administer coverage; and 4) conduct other legally permissible activities that relate to any coverage I (he/she) have (has) or have (has) applied for with OSGLI.

This authorization shall remain in force for 24 months following the date of my signature below, while the coverage is in force, except to the extent that state law imposes a shorter duration. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to OSGLI at: 290 West Mount Pleasant Avenue, Livingston, NJ 07039. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that OSGLI has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release my complete medical record, OSGLI may not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have the right to request and receive a copy of this authorization.

*Limits, if any:

X

Signature of service member, guardian or Attorney in Fact | Description of Authority

Date (MM DD YYYY)